JMC Care Ltd

Bluebird Care Great Yarmouth and Lowestoft

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bluebird Care Great Yarmouth and Lowestoft is a domiciliary care agency, providing personal care to people living in their own homes. There were 35 people receiving personal care at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The provider did not have an effective system to monitor and assess the quality and safety of the service people received. Record keeping in areas such as staffing, safeguarding and complaints was not robust and did not support the delivery of safe and effective care.

At our previous inspection we found some systems for checking the quality and safety of the service were not in place putting people at risk of harm. At that inspection this was a breach of the Regulations. At this inspection improvements were still needed to make quality assurance systems more effective, and the provider remained in breach.

Complaints had not been recorded or responded to appropriately. The provider had a complaints procedure: however, complaints made, along with lessons learned and action taken had not been recorded.

Safeguarding concerns were not always addressed appropriately. The provider had a safeguarding procedure; however, records were not kept of safeguarding investigations to demonstrate lessons learned to prevent a reoccurrence.

There were insufficient staff to meet people's needs consistently. Commissioned care packages for two care workers to undertake people's planned care visits were reduced by the provider to one care worker attending as they were unable to fulfil the care hours needed. We received concerns from people and their relatives of late and missed care visits.

People were supported by a staff team who were safely recruited and who had the relevant training and qualifications to safely support them.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
This service was registered with us on 7 October 2019 and this is their first comprehensive inspection. We carried out a 'focussed' inspection on 16 November 2020 to look at the key questions of Safe and Well-Led only. That inspection did not result in a rating; however, we did find a breach of Regulation 17: Good Governance. There was ineffective governance and oversight in place. At this inspection enough improvement had not been made and the provider was still in breach of the regulations.

You can see what action we have asked the provider to take at the end of this full report.

Why we inspected
This service was registered with us on 7 October 2019 and this is the first 'ratings' inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing, the submitting of notifications and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bluebird Care Great Yarmouth and Lowestoft

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience made telephone calls to people and their relatives to gain their feedback of the service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 8 July 2021 and ended on 29 July 2021. We visited the office location on 8 July 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.
We reviewed information we had received about the service since the last focused inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We visited the office location on 8 July 2021 and met with the registered manager, managing director and field supervisor. We reviewed a range of records which included risk assessments and care records for five people, and three staff files in relation to recruitment. We reviewed accident and incident records and management monitoring and oversight records remotely. We provided inspection feedback to the registered manager on 29 July 2021.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three people who receive care and support from Bluebird Care Great Yarmouth and Lowestoft about their experience and five relatives. We also had telephone calls and electronic feedback via email from a further three relatives and three staff members.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first comprehensive inspection for this service since registration. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● The majority of people and relatives we spoke with told us they felt their care was rushed, with care workers either arriving late for their visits or leaving early and not staying for the allotted time. One person said, "They are not on time usually and I often get different [care workers], they just mess me about." Another person said, "Most of the time if they are late it's because the agency isn't good at scheduling travel time in for them [care workers]." One person's relative commented, "We have also had several missed visits with no one turning up at all and no notification of a visit having to be cancelled. Also, my [family member's] visit times being changed without consultation."

● There were insufficient staff combined with poor staff deployment. We received information that some care visits were late and that two people who required two care workers to assist them, only had one care worker arrive over a period of time. One person, who was due to have two care workers to deliver their care had just one arrive for six consecutive days.

● The local authority told us of a further occasion where a person's care package had been commissioned for two care workers to support the person but the service had reduced it to one care worker as they did not have the care workers available to meet the package. This placed people at potential risk of harm.

The provider had failed to ensure there were sufficient numbers of staff employed to ensure people's care needs were met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● We spoke with the registered manager about the staffing levels, missed and late calls. The registered manager told us they were continually trying to recruit new care workers however they had also found that their 'double up round' system where two staff worked together to provide care to people who required two care workers, was not effective and they were looking to revise it.

● Staff were recruited safely. Staff files contained a full employment history, a record of the interview and evidence of satisfactory references and a Disclosure and Barring Service check.

Systems and processes to safeguard people from the risk of abuse

● We received mixed feedback about whether people felt safe with the care they received. One person's relative said. "There have been times that I've felt [family member] didn't feel safe. Examples come to mind that timings of visits can be sporadic and at times a carer has not showed up at all and no one has been informed. So, in those situations [family member] gets no care at all." The registered manager told us staffing had been a challenge, however, they were trying to recruit new staff.

● The service maintained a safeguarding log; however, this was not effective as it did not include all

safeguarding concerns raised for investigation that we were told about by the Local Authority Safeguarding team. This meant there was ineffective systems and processes to safeguard people from the risk of abuse.
● Care workers received training on safeguarding and understood how to recognise and report abuse. One care worker said, "I would go to [registered manager] or higher depending on who it is. I also know there's an NHS and social care whistleblowing service so if all else fails would contact them."

Assessing risk, safety monitoring and management
● Whilst there was a system for recording accidents and incidents, we found not all accidents were recorded and that the management team had not reviewed or undertaken detailed investigations to mitigate risk and reduce reoccurrence when instances had occurred.
● Where care plans had been created, and risks to people's health, welfare and safety had been identified, there was a lack of guidance for staff to follow, to protect people from harm. Risk assessments required further improvement to ensure staff were clear on any potential risks and steps to take to mitigate these were possible.

Learning lessons when things go wrong
● Accidents and incidents were recorded, and a log kept to maintain oversight and actions needed. However, due to not all injuries being recorded within the accidents and incident logs this was not effective in reducing the likelihood of a reoccurrence.
Using medicines safely
● Where people required support with administration and management of their prescribed medicine this was detailed in their care plan.
● Care workers completed electronic records when they had supported people with their medicines. If a delay occurred or the task was not completed during the scheduled visit an alert was sent to the office, so they could follow up.
● Care workers received training in medicines management and had their competencies assessed.
● The management team had implemented audits of the medicines system to ensure procedures followed were safe

Preventing and controlling infection
● People were protected from the risk of infection because care workers had been trained in infection control and followed the current national infection prevention and control guidance. One person told us, "They are wonderful with the PPE and hygiene. They change their gloves, it's impeccable."
● Care workers told us they were supplied with personal protective equipment (PPE) to help prevent the spread of infections and were clear on their responsibilities with regards to infection prevention and control.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first This is the first comprehensive inspection for this service since registration. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● We received mixed feedback about whether care workers had the skills and knowledge to meet people's needs. One person's relative said, "I don't get the impression that staff are well trained. Staff generally like to keep [family member] happy and entertained with cheerful chat but I've experienced [family member] being talked over and talked about when they are in the room and I don't get the impression that the needs of people [living] with dementia are well understood." Another relative, however, said, "I think staff training is okay, they do what they should do and help [family member] with their routine."

● Care workers had received training in areas considered by the provider to be mandatory. Records showed that training provided included safeguarding, moving and handling, dementia and medicines, amongst others.

● Care workers told us they felt trained and supported in their roles. One care worker said, "I feel supported from other carers as we are all in the same boat some days so I would say we try to support each other. The office is pretty supportive but on occasions it seems like they don't have time to listen if a problem comes up. Generally, though, they are supportive."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before any care was provided.

● Information gathered during assessments was used to create individual plans of care and support. These plans reflected people's needs and were mostly detailed and person centred.

● Care workers told us they found the care plans useful and informative in meeting people's needs. We also found, however there were areas where the care plans could be improved, especially to reflect where people had two care workers and what the role of each care worker had in the delivery of care.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet

● People and their relatives spoke positively about the support provided to meet nutrition and hydration needs. One relative said, "They check [family member] has had their breakfast and will leave food for [family member] to have when they are ready."

● Information was documented in people's care records which provided guidance for care workers on how to meet individual needs and preferences.

● Within each person's care plan there was information about any like and dislikes and preferences along with consideration of potential risks such as care workers serving undercooked food or risks of food poisoning.

Supporting people to live healthier lives, access healthcare services and support
● Where necessary, the service worked with other services to deliver effective care and support.
● People's records showed that where other professionals were involved their input was added to care plans.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People and their relatives told us the care workers sought their consent before providing any care or support. One relative said, "They ask for [family member's] consent, they'll say, 'shall we get you up?' They have a laugh with [family member]and they jolly them along."
● Care workers received training on the MCA which covered obtaining people's consent prior to delivering any care and the principles of the MCA.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first comprehensive inspection for this service since registration. This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People's needs had not consistently been met in a timely way. Two people who were commissioned to have two carer workers deliver their care did not always received this due to a shortage of staff. Some family members told us they had experienced changes in visit times without consultation. This was not respectful of people's needs.
- We received concern from some people's relatives about a financial cost for their family member and themselves, where appropriate, to access the person's care plan electronically. We discussed this with the registered manager to ascertain how people were able to access their care records without incurring costs. The registered manager told us that paper copies were available and that the fee for accessing the electronic version was, "A provider level decision", however, following our discussions, this fee would be removed.
- We received lots of positive feedback about people's support and the caring nature of the care workers. One person told us, "They are kind and caring, all of them. They chat and make me feel comfortable." Another person commented, "I think they are kind and caring and treat me with dignity."
- Relatives spoke positively of care workers, telling us they were kind and considerate when providing care. One relative commented, "On the whole they are compassionate and gentle." Another relative said, "They are kind and caring with my relative, I can hear chatter and lots of laughter when they are there."

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us care workers respected people's privacy and dignity and promoted independence. One relative said, "They treat [family member] well, they are brisk and efficient and ensure [family member's] dignity. They let [family member] manage but would step in if necessary."
- Care workers gave examples of how they respected people's privacy and would actively promote their independence. Practice to promote privacy was embedded within care records. One care worker told us, "We help people with their care whilst we have a chat with them and gosh do, we chat. We always give a choice, like do they fancy a bath or a shower or what do they fancy wearing. We try and help people be independent for as long as possible."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first comprehensive inspection for this service since registration. This key question has been rated Requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Complaints and concerns raised were not always logged on the provider's system. This meant there was no formal record of the complaint and any actions taken to learn and prevent a reoccurrence in line with their complaints policy.
- People's relatives and the local authority told us of complaints made in the past year. However, these were not recorded on the complaints log, only one entry had been made despite us being told of more.
- Several people's relatives told us of complaints that had been resolved to their satisfaction by the registered manager. However, the lack of effective record keeping meant there was no evidence that lessons were being learned.

The failure to manage complaints appropriately is a breach of Regulation 16 (receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider had an electronic system which required care workers to log in when they arrived and left a person's home. However, some people's visit times were not always consistent with those agreed or detailed in their care plan.
- People had individualised care plans which detailed their care and support needs.
- People's needs, and expectations of their care had been documented within their care plan, which included their preferences. For example, the order in which they liked their care to be provided and included areas they were independent in.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service was complying with AIS and where required information could be provided to people in alternative formats such as pictorial format, large print and easy read to enable them to access the information in a way they could understand.

End of life care and support

- Whilst no one was currently approaching the end of their life, the service did offer people the option of receiving end of life care in their own homes.

● The service linked up with external healthcare professionals as required to ensure people were well supported and enabled to have their end of life wishes met wherever possible.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first comprehensive inspection for this service since registration. This key question has been rated Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- We found continued issues with management oversight, monitoring of complaints and visit times and attendance. These were all identified at the previous focused inspection. Improvements had not been made in these areas and people were still at risk of not having their needs met.
- Whilst there were systems in place to record safeguarding concerns and complaints, records did not evidence that all had been logged and actions taken as a result. This put people at risk of harm as there was no evidence of how they had been investigated, the outcomes and lessons being learned to prevent a re-occurrence. This had not been identified as an issue in the provider's own quality assurance processes.
- Commissioned care packages were not always delivered, due to not having enough care workers to cover them.
- There was limited evidence of provider oversight. Improvements were required to provider level quality assurance processes to ensure all shortfalls in service quality were identified and acted on in a timely way.
- People had opportunities to provide feedback about their care as part of their service reviews, which included any actions needed to be taken. However, there was no analysis conducted of the themes arising from these surveys and no record of how any feedback or concerns had been acted on.

The provider failed to have systems and processes in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had failed to notify CQC about all safeguarding allegations or incidents. This is a requirement of the provider's registration so that where needed, CQC can take follow-up action.

The failure to notify CQC appropriately is a breach of the Care Quality Commission (Regulations) 2009 Regulation 18

- The registered manager told us that changes were being made to the office set up with additional support being put in place, such as a deputy manager, to enable the registered manager to focus on increasing their oversight.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Promoting a positive culture that is person-centred,

open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider did not always demonstrate they understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information. We heard from one commissioning authority that following an accident the provider had made no contact with the person's relative to update, discuss or check on the welfare of the person.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not sent the Commission statutory notifications, were not received as required.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to manage complaints appropriately.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's care visits.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Warning Notice